

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1367. COVERAGE OF CHILDREN

SUBCHAPTER A. NEWBORN CHILDREN

Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan delivered or issued for delivery in this state that is an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter [842](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter [1201](#), including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN CHILDREN PROHIBITED. A health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not be issued in this state if the plan excludes or limits:

(1) initial coverage of a newborn child for a period of time;

(2) coverage for congenital defects of a newborn child; or

(3) coverage for administration of the newborn screening tests required by Section [33.011](#), Health and Safety Code, including for the cost of a newborn screening test kit in the amount provided by the Department of State Health Services on its Internet website under Section [33.019](#) of that code on the date the test was

administered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 599 (S.B. 747), Sec. 5, eff. September 1, 2019.

SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.052. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or for another limited benefit;
 - (B) only for accidental death or dismemberment;
 - (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (D) as a supplement to a liability insurance policy;
 - (E) for credit insurance;
 - (F) only for dental or vision care; or
 - (G) only for indemnity for hospital confinement;
- (2) a small employer health benefit plan written under Chapter [1501](#);
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section [1367.051](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide for each covered child from birth through the date of the child's sixth birthday coverage for:

- (1) immunization against:
 - (A) diphtheria;
 - (B) haemophilus influenzae type b;
 - (C) hepatitis B;
 - (D) measles;
 - (E) mumps;
 - (F) pertussis;

- (G) polio;
- (H) rubella;
- (I) tetanus; and
- (J) varicella; and

(2) any other immunization that is required for the child by law.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section [1201.061](#), [1201.062](#), [1201.063](#), or [1201.064](#).

(c) In addition to the immunizations required under Subsection (a), a health maintenance organization that issues a health benefit plan shall provide under the plan coverage for immunization against rotovirus and any other immunization required for a child by law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 3B.0281, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. [3167](#)), Sec. 9.0281, eff. September 1, 2007.

Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENT PROHIBITED. (a) Coverage required under Section [1367.053](#)(a) may not be made subject to a deductible, copayment, or coinsurance requirement.

(b) This section does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.055. RULES. The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. [2018](#)), Sec. 11.039, eff.

September 1, 2005.

SUBCHAPTER C. HEARING TEST

Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 842;

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

(b) This subchapter applies to a health benefit plan described by Subsection (a) that provides coverage to a resident of this state, regardless of whether the plan issuer is located in or outside this state.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.102. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or for another limited benefit;
 - (B) only for accidental death or dismemberment;
 - (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (D) as a supplement to a liability insurance policy;
 - (E) for credit insurance;
 - (F) only for dental or vision care; or
 - (G) only for indemnity for hospital confinement;
- (2) a small employer health benefit plan written under Chapter 1501;
- (3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- (4) a workers' compensation insurance policy;
- (5) medical payment insurance coverage provided under a motor vehicle insurance policy; or
- (6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.101.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:

- (1) a screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and
- (2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or

enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section [1201.061](#), [1201.062](#), [1201.063](#), or [1201.064](#).

(c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:

(1) employed outside this state; and

(2) covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED; NOTICE REQUIRED. (a) Coverage required under this subchapter:

(1) may be subject to a copayment or coinsurance requirement; and

(2) may not be subject to a deductible requirement or a dollar limit.

(b) The requirements of this section must be stated in the coverage document.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.105. RULES. The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is

offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter 842;
- (iii) a fraternal benefit society operating under Chapter 885;
- (iv) a stipulated premium company operating under Chapter 884; or
- (v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

- (i) a multiple employer welfare arrangement as defined by Section 3 of that Act;
- (ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or
- (iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.152. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:
 - (A) only for a specified disease or for another limited benefit;
 - (B) only for accidental death or dismemberment;
 - (C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
 - (D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement or other hospital expenses;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.151.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES; DEFINITION REQUIRED. A health benefit plan that provides coverage for a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" under the plan to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1367.154. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER E. DEVELOPMENTAL DELAYS

Sec. 1367.201. DEFINITION. In this subchapter, rehabilitative and habilitative therapies include:

(1) occupational therapy evaluations and services;

- (2) physical therapy evaluations and services;
- (3) speech therapy evaluations and services; and
- (4) dietary or nutritional evaluations.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.202. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (A) an insurance company;
- (B) a group hospital service corporation operating under Chapter 842;
- (C) a fraternal benefit society operating under Chapter 885;
- (D) a stipulated premium company operating under Chapter 884;
- (E) a health maintenance organization operating under Chapter 843; or
- (F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.203. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.202.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.204. OFFER OF COVERAGE REQUIRED. (a) A health benefit plan issuer must offer coverage that complies with this subchapter.

(b) The individual or group policy or contract holder may reject coverage required to be offered under this section.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.205. COVERAGE OF CERTAIN THERAPIES. (a) A health benefit plan that provides coverage for rehabilitative and habilitative therapies under this subchapter may not prohibit or

restrict payment for covered services provided to a child and determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.

(b) Rehabilitative and habilitative therapies described by Subsection (a) must be covered in the amount, duration, scope, and service setting established in the child's individualized family service plan.

(c) A child is entitled to benefits under this subchapter if the child, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.206. PROHIBITED ACTIONS. Under the coverage required to be offered under this subchapter, a health benefit plan issuer may not:

(1) apply the cost of rehabilitative and habilitative therapies described by Section 1367.205(a) to an annual or lifetime maximum plan benefit or similar provision under the plan; or

(2) use the cost of rehabilitative or habilitative therapies described by Section 1367.205(a) as the sole justification for:

(A) increasing plan premiums; or

(B) terminating the insured's or enrollee's participation in the plan.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

Sec. 1367.207. RULES. The commissioner may adopt rules necessary to implement this subchapter.

Added by Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.040(a), eff. September 1, 2005.

SUBCHAPTER F. HEARING AIDS AND COCHLEAR IMPLANTS

Sec. 1367.251. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage provided through a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a Lloyd's plan operating under Chapter 941;
- (5) a stipulated premium insurance company operating under Chapter 884;
- (6) a reciprocal exchange operating under Chapter 942;
- (7) a health maintenance organization operating under Chapter 843;
- (8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
- (9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) This subchapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy, agreement, or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) This subchapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(d) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this subchapter applies to health benefits

provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code.

(e) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this subchapter applies to a regional or local health care program operated under that section.

(f) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this subchapter.

(g) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this subchapter applies to:

- (1) a basic coverage plan under Chapter 1551;
- (2) a basic plan under Chapter 1575;
- (3) a primary care coverage plan under Chapter 1579;

and

- (4) basic coverage under Chapter 1601.

Added by Acts 2017, 85th Leg., R.S., Ch. 979 (H.B. 490), Sec. 1, eff. September 1, 2017.

Sec. 1367.252. EXCEPTION. This subchapter does not apply to:

- (1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy;

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the

policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section [1367.251](#); or

(6) the state Medicaid program, including the Medicaid managed care program operated under Chapter [533](#), Government Code. Added by Acts 2017, 85th Leg., R.S., Ch. 979 (H.B. [490](#)), Sec. 1, eff. September 1, 2017.

Sec. 1367.253. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage for the cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is 18 years of age or younger.

(b) Coverage required under this section:

(1) must include:

(A) fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;

(B) any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and

(C) for a cochlear implant, an external speech processor and controller with necessary components replacement every three years; and

(2) is limited to:

(A) one hearing aid in each ear every three years; and

(B) one cochlear implant in each ear with internal replacement as medically or audilogically necessary.

(c) Except as provided by Subsections (b) and (d), coverage required under this section:

(1) may not be less favorable than coverage for physical illness generally under the plan; and

(2) must be subject to durational limits and coinsurance factors no less favorable than coverage provided for physical illness generally under the plan.

(d) Coverage required under this section is subject to any provision that applies generally to coverage provided for durable medical equipment benefits under the plan, including a provision

relating to deductibles, coinsurance, or prior authorization.

(e) This section does not apply to a qualified health plan defined by 45 C.F.R. Section 155.20 if a determination is made under 45 C.F.R. Section 155.170 that:

(1) this subchapter requires the plan to offer benefits in addition to the essential health benefits required under 42 U.S.C. Section 18022(b); and

(2) this state must make payments to defray the cost of the additional benefits mandated by this subchapter.

Added by Acts 2017, 85th Leg., R.S., Ch. 979 (H.B. [490](#)), Sec. 1, eff. September 1, 2017.